Assisted Living Advisory Workgroup Meeting
Tuesday, September 11, 2003
Office of Health Care Quality
Spring Grove Hospital Center
55 Wade Avenue
Catonsville, Maryland

Meeting Agenda

T E N T A T I V E A G E N D A

Sub-workgroup Meeting – Class "A" Provider 1:00 PM to 2:00 PM

Topics of discussion will include program requirements for multiple campus providers or multis.

Full Advisory Workgroup Meeting 2:00 PM to 3:00 PM

I. Call to Order

II. Review of Agenda

III. Review of Meeting Notes from the August 27, 2003, Meeting

IV. Discussion: Medication Administration

V. Next Steps

- Reminder: The next Advisory Workgroup meeting will be held on Wednesday, September 17, 2003, in the basement conference room of the Dix Building located on the campus of Spring Grove Hospital Center.

- Future Meeting Dates Needed

VI. Adjourn

Meeting Notes

In Attendance

- Carol Benner, Chair
- Lissa Abrams
- Dorinda Adams
- Marie Ikrath
- Karin Lakin
- Sharon Olhaver
- Jeff Pepper
- Ilene Rosenthal
- Jim Rowe
- JoAnn Stough

Advisory Workgroup Members Absent

- Valerie Colmore
- Bonnie Gatton
- Laura Howell
- Ron Jeanneault
- Susan Quast
- Jill Spector

Stakeholders Present

- Denise Adams, Maryland Department of Aging
- Karen Acton, Sunrise Senior Living
- Fran Blacker, Golden Age Retirement
- Debra Campbell, Montgomery County
- Lauren Carbo Tranquillity
- Paula Carder, UMBC
- Linda Cole, Maryland Health Care Commission
- Sabrina Cooley, Lorien
- Matt Decker, Sunrise Senior Living
- Sister Irene Dunn, Vicotry Housing
- Darlene Fabrizio, Somerford Corporation
- Mary Farber, Lorien
- Mayer Handleman, ASCP and Ocean Pines
- Sharon Kruskamp, Asbury Methodist Village
- Monir Mamoudi, Golden Years
- Betty Otaro, Howard County
- Catherine Putz, Maryland Board of Pharmacy
- Bruce Raffel, Catered Living

- Kathy Sarneicki, Maryland Department of Human Resources
- Sushant Sidh, Mid-Atlantic LifeSpan
- Susan Shubin, Legal Aid Bureau
- Janice Torres, Baltimore City

Staff Present

- Lynn Condon, Education and Training Supervisor
- Yvette Dixon, Special Assistant
- William Dorrill, Deputy Director State Programs
- Kimberly Mayer, Policy Analyst
- Cheryl Reddick, Assisted Living Program
- Valerie Richardson, Assisted Living Program

Introductions

Carol Benner, Director of the Office of Health Care Quality at the Department of Health and Mental Hygiene, called the meeting to order at approximately 1:00 PM. Ms. Benner thanked those present for their interest in Maryland's assisted living program.

Discussion: Regulation of Multiple Campus Providers or Multis

Ms. Benner brought to the members of the Advisory Workgroup and the stakeholders present attention that the concept of an alphabetically or numbered classification for the different licensure categories being considered may invoke connotations that level A licensure category is better than a level B licensure category. Therefore, the group may want to consider developing names to go with the different categories.

Staff offered three name options for consideration. The Advisory Council members and stakeholders present generally favored the use of names versus an alphabetic or numbered classification. There was discussion about concerns of possible liability insurance impact, but it was noted that all of these categories would be governed and regulated under COMAR 10.07.14 – Assisted Living Programs. Therefore, it was agreed that there appeared that there may not be adverse impact on providers with using different names for the various licensure categories being contemplated.

The following terms were agreed to by a consensus of the stakeholders present and members of the Advisory Workgroup for consideration. These terms will be reviewed and discussed again at the next meeting:

(1) Assisted Living Programs would apply to the licensure category previously discussed as Class "A" or referred to as a large provider. The term Assisted Living Program would apply to either a *residential or facility-based* program that has a total number of beds equal to or greater than 17 beds that provide housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of residents who are

unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that promotes optimum dignity and independence for residents.

(2) Residential Care Homes would apply to either a *residential or facility-based* program that has a total number of beds equal to four or less than 16 beds that provide housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of residents who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that promotes optimum dignity and independence for residents.

(3) Adult Family Homes would apply to a private home that would be registered home with the Department of Health and Mental Hygiene and where one to three persons who are dependent, elderly and/or have disabilities, live and receive care and services from a care provider who is not related to them by blood, adoption, or marriage. Persons who live in Adult Family Homes and receive care and services are called residents. *The primary caregiver for the residents also resides at the home and is generally the head of the household.* The Adult Family Home may receive a government subsidy to care for the resident, if the resident qualifies for the program, or may charge the resident for room and board and minimal services.

Ms. Benner asked those present to review these terms as they will be discussed again at the next Advisory Workgroup meeting. Also, should anyone in the interim come up with other options for terms to bring those to the next meeting for consideration as well.

It was noted that there was some confusion at the conclusion of the last meeting's discussion on multiple campus providers specifically concerning the licensing structure being considered.

The issue of common ownership is one that the Advisory Workgroup has been struggling with for several work sessions. It was suggested at the last meeting that the definition used by the Centers for Medicare and Medicaid Services in its Ownership and Control Interest Statement (CMS-1513) may address this issue. The definition extrapolated from the CMS-1513 document is as follows:

- Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity.

- Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity.

- Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity

(i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or names members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

The Advisory Workgroup and the stakeholders present supported the use of this definition. The Department could add a disclosure of ownership and control interest statement to the licensure application for assisted living programs and residential care homes.

Consensus Statement: The Department of Health and Mental Hygiene should either add a section to the current licensure application for assisted living programs and residential care homes or require that owners complete a disclosure of ownership and control interest statement.

It was suggested that perhaps a blended or combination type licensing structure would be effective in regulating multiple campus or multi providers. This blended structure would provide that each home be licensed separately, but that the owners of multiple programs could register with the Department. The registration would provide the mechanism by which the Department could be made aware of operators that have interest in multiple assisted living programs or residential care homes, as well as provide for an opportunity for operators to take advantage of some level of regulatory flexibility or economies of scale.

A sub-workgroup comprised of multiple campus providers or multis was asked to review the current regulations to determine where the regulatory burden could be reduced without adversely impacting quality of care and where it was appropriate for economies of scale to be used should registration be considered. The sub-committee members are Karin Lakin, Bruce Raffel, Sabrina Cooley, Jeff Pepper, Mary Farber, and Sister Irene Dunn. Ms. Benner asked that the sub-committee report back recommendations at the next Advisory Workgroup meeting.

Discussion: Medication Administration

In previous meetings, it has been noted that medication administration was an issue in assisted living at all levels and in all types of programs. It is also a universal theme echoed across all community-based programs. Ms. Benner acknowledged that medication administration is a very large, complex and emotional issue for programs as well as families. She asked that the Advisory Workgroup and stakeholders focus on those areas that make sense for government to take action to improve. She reminded those present

that when she signs a license it is a statement to the public that the program has met certain criteria and is safe.

Note: For the purpose of the medication administration discussion all programs – assisted living program and residential care programs – will be referred to as assisted living residences.

There was considerable discussion about medication administration issues and three areas were noted: what is it that we need to know; what is the ability of the resident; and, what kind of relationship exists between the resident's physician, the delegating nurse and the assisted living residence.

The Advisory Workgroup and stakeholders present reviewed recommendations made by the nationally focused Assisted Living Workgroup to the U.S. Committee on Aging on the issue medication administration that achieved a consensus among a two-thirds majority of that workgroup. The discussion was as follows:

Recommendation of the Assisted Living Workgroup:	Advisory Workgroup and Stakeholder Discussion:
Prior to signing the residency agreement, the assisted living residence will disclose and explain in easily understood language policies, procedures, and service capacity relevant to the medication management needs of the residents and associated costs, including the disposition of medications.	It was the consensus of the Advisory Workgroup and stakeholders present that this recommendation should be adopted.
It is the responsibility of the resident who is self-administering medication to provide the assisted living residence with a written list of all prescribed and over-the-counter medication use and changes. When the resident is reassessed for continued ability to self-administer or manage medications, the list of current medications will be updated.	It was the consensus of the Advisory Workgroup and stakeholders present that this recommendation should be adopted, but that herbal supplements and vitamins should be included as well.
For residents whom the assisted living residence administers medication, an authorized prescriber(s) shall prescribe all medication, including over-the-counter medications. Such orders are kept current for all medications. The facility shall develop a process to ensure that the primary care physician be kept aware of all medications taken by the resident.	It was the consensus of the Advisory Workgroup and stakeholders present that this recommendation should be adopted, but that herbal supplements vitamins should be included as well.

- Medication assistive personnel (MAP) may administer medications after successfully completing a state approved training course that includes a written and performance-based competency examination. To qualify for training as a MAP, the individual shall be a high school graduate (or equivalent) and have English language proficiency.

There was considerable discussion about this recommendation. The Department has deferred to the Maryland Board of Nursing for the development of a more rigorous training program with a competency examination and some type of supervised practicum for certified medication assistants; as well as, the development of a training program for delegating nurses.

Many stakeholders echoed concerns about the current labor pool and making the requirements too restrictive could adversely affect providers. Many providers employ individuals who have not completed high school and do not possess a GED or who have attended high school in foreign countries and cannot provide the appropriate documentation.

Everyone agreed that the MAP should have English language proficiency and the ability to read and write. It was suggested that perhaps some type of pretest for proficiency in these areas could be developed.

It was suggested that limiting the total amount of times that an individual may take the competency examination or instituting some type of requirements similar to the ones currently in place for geriatric nursing assistants may be an option (i.e., within one calendar year from the time in which training was received take and successfully complete the examination. If the individual fails three times they must be retrained); however, this would require that these individuals be tracked which is not being done at this point.

Barbara Newman from the Maryland Board of Nursing was asked to look into this issue and report back at the Advisory Workgroup's next meeting.

It was noted that there exists in the assisted living residence community a large issue of whether or not family members should be given the ability to administer medications to their loved ones as currently permitted in regulation. However, this practice raises a lot of safety concerns not only for the loved one who is a resident, but for other residents and could contribute to medication errors unknown to the provider. As a result, many assisted living residences have developed, in addition to their policies and procedures, risk management agreements to address liability issues.

It was noted that there are three options to deal with the family member administration issue: (1) to maintain the current regulations; (2) require that assisted living residences have risk agreements or waivers from family members who request to administer medications to their loved ones; or (3) forbid family member administration. This issue will be discussed further at the next Advisory Workgroup meeting.

Advisory Workgroup Meeting Schedule

- Assessment Tool Sub-Workgroup – please contact Lynne Condon at 410-402-8102 for the meeting schedule.

- Multiple Campus Providers – Operator Registration Sub-Workgroup – please contact Karin Lakin at 301-749-7611 for the meeting schedule.

- Next Assisted Living Advisory Workgroup Meeting Date –Wednesday, September 17, 2003, from 9:00 AM to 12:00 Noon in the basement conference room of the Dix Building located on Dogwood Circle on the campus of Spring Grove Hospital Center.

There being no further business before the Assisted Living Advisory Workgroup or its sub-workgroups, the meeting adjourned at approximately 3:00 PM.

Meeting notes prepared by: Kimberly Mayer